# MEDICAL RECORD RELEASE FORM

RETURN

PRIMARY CARE HOUSE CALLS

2744 Gulf Breeze Pkwy, Gulf Breeze, FL 32563

Phone: 850-934-5713 Fax: 850-934-0379

_____ _____

Patient Name Date of Birth

I request and authorize the below listed entity to release medical information to Primary Care House Calls.

Name: _____ Telephone: _____

Address: _____ Fax: _____

_____

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Medical Information Requested:

1. All Records
2. Specific Records from_____ to_____
3. Immunization & Physical Examinations
4. Radiology Films (X-Ray, Mammography, Ultrasound, CT, MRI, etc.)
5. Discharge Summary
6. History and Physical
7. Lab Results
8. Consultation

_____

Signature of Patient or Legal Guardian Date

I understand that these records are protected under and State law and cannot be disclosed without written consent unless otherwise provided by law. I further understand that the specific type information to be disclosed may, if applicable include: diagnosis, prognosis, and treatment for physical and/or mental illness, including treatment of alcohol for substance abused, auto-immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection for any admission. I understand that I have the right to revoke this consent at any time in writing unless the facility, which is to make the disclosure of information, has already done so in reliance on the consent.